Missouri Pharmacy Program – Preferred Drug List

Agents for Cryopyrin-Associated Periodic Syndrome (CAPS)

Effective 11/01/2004
Revised 10/3/2013

Preferred Agents

- Ilaris®

Non-Preferred Agents

- Arcalyst®

Approval Criteria	Denial Criteria
• Documented compliance on current therapy regimen	Lack of adequate trial on required preferred agents
• Failure to achieve desired therapeutic outcomes with trial on 1 preferred agents o Documented trial period for perferred agents o Documented ADE/ADR to preferred agents	Therapy will be denied if no approval criteria are met
• Appropriate Diagnosis o Cryopryin-associated periodic syndrome (CAPS) o Familial Cold Autoinflammaotry Syndrome (FCAS) o Familial Cold Uticaria (FCU) o Muckle-Wells Syndrome (MWS) o Neonatal-Onset Multisystem Inflammatory Disease (NOMID)	Patients less than 12 years old for Arcalyst therapy
	Patient less than 4 years old for Ilaris therapy
	Concurrent Tumor Necrosis Factor (TNF) blocking agent therapy
	Drug Prior Authorization Hotline: (800) 392-8030